CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF PETAR JOSIPOVIC

[2026] SACC 31

Inquest Findings of his Honour State Coroner Whittle

13 August 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man while waiting for cardiothoracic surgery. The inquest explored the circumstances surrounding a delay in performing the surgery, and in particular the circumstances that led to multiple cancellations of scheduled surgery dates.

Held:

1. Petar Josipovic, aged 62 years of Pennington, died at the Royal Adelaide Hospital on 14 September 2023 as a result of multi-organ failure on a background of aortic regurgitation and ischaemic heart disease (operated).

2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MS E ROPER

Interested Party: CENTRAL ADELAIDE LOCAL HEALTH NETWORK
Counsel: MR S PLUMMER - Solicitor: CROWN SOLICITOR

Witness: DR V GUNASAEGARAM, MS D THOMPSON, DR S EMMANUEL, DR A HARDIKAR & DR F VIANA
Counsel: MR S PLUMMER - Solicitor: CROWN SOLICITOR

Hearing Date/s: 09/04/2025-11/04/2025, 14/04/2025 & 23/04/2025

Inquest No: 7/2025 **File No/s: 2426/2023**

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INQUEST INTO THE DEATH OF PETAR JOSIPOVIC [2026] SACC 31

Introduction

1 I heard an inquest in relation to the death of a 62-year-old man who was waiting for cardiothoracic surgery to deal with aortic valve regurgitation and coronary artery disease. The surgery was identified as urgent but was unable to be completed within the target timeframe due to other urgent cases arising that were considered of higher priority. I explored whether there were any systemic issues arising in the decision-making that led to the cancellations.

2 I heard evidence from those involved in the assessment and planning of Mr Josipovic's surgery and I was assisted by evidence from the Head of the Cardiothoracic Surgical Unit at the Royal Adelaide Hospital, Dr Ashutosh Hardikar, as well as independent expert evidence from Professor Julian Smith, a respected senior cardiothoracic surgeon with decades of experience.

These findings

3 The standard of proof to be applied in coronial findings is the civil standard; the balance of probabilities. Where I express a finding of fact in these findings, I have done so on the basis that I am satisfied that that fact was proved as more likely than not on the basis of the evidence I heard and received and consider reliable. In considering making findings which imply or express criticism of individuals, I am guided by the principle enunciated in *Briginshaw v Briginshaw*[1] and I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made taking into account the nature and potential consequences of the finding.

4 In these findings I shall not summarise all the evidence tendered or heard during the inquest but refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

5 In these findings, I will refer to all surgeons involved by the title 'Dr' in accordance with the position and practice of the Royal Australasian College of Surgeons, addressing the use of gendered titles.

Petar Josipovic

6 Petar Josipovic was born in Zavidovići in Bosnia and Herzegovina on 2 June 1961. He married Finka Josipovic and became the father of two sons, Marko and Nikica. The Josipovic family migrated to Adelaide on 1 April 1995, without monetary assets and with no prior knowledge of the English language. Mr Josipovic dedicated himself to his family, working as a tiler and then as a maintenance technician. He continued to work full time until about seven weeks before his death. He was devoted to his grandchildren.

7 Mr Josipovic was generally fit and well until about December 2022, when he began to experience shortness of breath. His past medical history included emphysema and an

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[1] *Briginshaw v Briginshaw* (1938) 60 CLR 336

unruptured abdominal aortic aneurysm, which was repaired surgically in August 2021. He also experienced chronic back pain.

Shortness of breath

8 Investigations into the cause of Mr Josipovic's shortness of breath commenced following a presentation to The Queen Elizabeth Hospital (TQEH) on 5 February 2023. The medical notes indicate that Mr Josipovic reported a three-day history of marked shortness of breath on mild exertion.[2] The differential diagnoses were listed as mild exacerbation of chronic obstructive pulmonary disorder (emphysema) and possible heart failure with preserved ejection fraction. A recommendation was made for his general practitioner to refer him for an echocardiogram, cardiology review and respiratory review. These referrals were made and appointments were attended by Mr Josipovic.[3]

9 Mr Josipovic was first reviewed by cardiologist, Dr Shahid Hafeez, on 7 February 2023.[4] He arranged for Mr Josipovic to wear a Holter monitor to collect data about his heart performance. He then performed a transthoracic echocardiogram on 21 February 2023.[5] This was noted to be technically difficult with suboptimal image quality, and that the aortic valve was not well visualised in the imaging produced.[6] The left ventricular ejection fraction was 55% visually, and Dr Hafeez concluded that Mr Josipovic had moderate to severe aortic regurgitation in the setting of dilated aortic root. Further evaluation was recommended.

10 On 5 March 2023, Mr Josipovic attended TQEH complaining of exertional dyspnoea. Mr Josipovic reported shortness of breath on exertion, bending down and on certain movements. He reported that four episodes had occurred that day.[7] He was discharged into the care of his regular general practitioner, Dr Faisal Chaudhary.

11 On 28 March 2023, Mr Josipovic attended TQEH for a transoesophageal echocardiogram. The scan revealed that by this time, Mr Josipovic's ejection fraction had reduced to 40-45%, indicating left ventricular dysfunction.[8] This represented a significant change over the span of a month, indicating that Mr Josipovic's aortic regurgitation was progressing faster than the typical rate.[9]

12 A coronary angiogram was performed on 26 April 2023.[10] This revealed a total coronary artery calcium score of 247 which correlates with the 60th percentile with moderate plaque burden. The left anterior descending artery had moderate mixed atheroma resulting in up to 50-69% stenosis, but with a slight exaggeration due to mural bridging. There was calcified plaque resulting in 1-24% luminal narrowing. The aortic root was dilated at the sinus of Valsalva level and the ascending thoracic aorta was dilated at the pulmonary trunk level.

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2 Exhibit C12 at 236
3 Exhibit C4 at 16
4 Exhibit C4 at 17
5 Exhibit C12 at 147
6 Exhibit C12 at 150
7 Exhibit C12 at 213
8 T585
9 T586
10 Exhibit C4 at 37-38

13 On 1 May 2023, a CT angiogram was performed.[11] This confirmed once again that the aortic root and ascending thoracic aorta were dilated, although there was no evidence of this worsening since 26 April 2023. There was evidence of the previous repair to the abdominal aorta.

14 Mr Josipovic's case was discussed at a multidisciplinary team (MDT) meeting at TQEH on 17 May 2023.[12] This meeting was attended by medical professionals from TQEH as well as from the Cardiothoracic Surgical Unit at the Royal Adelaide Hospital (the CTSU).[13] During the meeting, a slide of a Powerpoint presentation was displayed summarising Mr Josipovic's aortic regurgitation and dilatation of aortic structures.[14] Royal Adelaide Hospital consultant cardiothoracic surgeon, Dr Fabiano Viana, was present and accepted Mr Josipovic's case for outpatient surgical review. The team requested that an angiogram be performed at TQEH because there were signs of moderate disease on CT scan. A cardiology registrar, Dr Joshua Lushington, then sent a formal referral document, known as an M60 referral, to the CTSU.[15] On the M60, Dr Lushington indicated a 'suggested urgency' of 10 weeks. On the information known at this time, this was an appropriate suggestion. The referral was directed to Dr Viana who had been present during discussion of the case.

15 The coronary angiogram requested by the MDT was performed on 29 May 2023.[16] This once again confirmed the diagnoses made in earlier scans. There was 60% stenosis to the proximal left anterior descending artery. Other vessels had minor irregularities. A fractional flow reserve test was conducted with the infusion producing an FFR value of 0.77. The conclusion was therefore that there was a haemodynamically significant blockage. The procedure confirmed single-vessel coronary artery disease in addition to the aortic valve regurgitation. Two recommendations were made. The first was for aggressive risk factor modification (ie reduction of cholesterol level and blood pressure). The second was to continue the work up towards surgery.

Cardiothoracic surgical services in South Australia

16 There are two cardiothoracic surgical services within South Australia. One is provided by the CTSU at the Royal Adelaide Hospital under management of the Central Adelaide Local Health Network. The other is provided at the Flinders Medical Centre under management of the Southern Adelaide Local Health Network.

17 In 2022, approximately 700 cardiothoracic surgeries were performed in the CTSU, managed by four senior surgeons, each working less than full time, together with other supporting clinicians. In July 2023, Dr Hardikar joined the CTSU full time,[17] raising the senior staffing to 3.68 full-time-equivalent surgeons. There are two theatres available to the CTSU. This combination allowed 18 slots for procedures each week. Dr Hardikar was previously the Head of the Cardiothoracic Surgical Unit at the Royal Hobart

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11 Exhibit C4 at 38-39
12 Exhibit C8 at 7
13 T438
14 Exhibit C15 at 19
15 Exhibit C12 at 90, with the record being typed the following morning
16 Exhibit C12 at 92 and T581
17 T282

Hospital[18] and is held in high regard in the profession. In December 2023, Dr Hardikar was appointed as the Director of the CTSU.

18 By 2024, the number of surgeries performed in the CTSU increased to 1,000.[19] This, once again, necessitated an increase in staffing and two additional surgeons were recruited.[20]

Outpatient clinic review

19 On 13 June 2023, Mr Josipovic attended the CTSU outpatient clinic for review. He was assessed by Dr Viana with the assistance of cardiothoracic registrar Dr Christopher Robins.[21] Dr Viana gave evidence during the inquest. He told the Court that he had no independent recollection of meeting Mr Josipovic on 13 June 2023. Reliance was therefore placed upon the letter of Dr Robins, which appeared to be a contemporaneous and reliable record of the consultation.[22] Dr Robins wrote:

> Thanks for referring Petar for consideration of SAVR and ascending aorta replacement. I have reviewed Petar in Mr Viana's clinic today. He is a lovely gentleman who has a past medical history of COPD, AAA repair Aug 2021, current smoker. He lives with his wife and works as a maintenance officer at a nursing home, independent with ADLs.
>
> His regular medication includes aspirin, ramipril and salbutamol. Petar complains of some SOB which begun in Feb this year which has been worked up and found moderate AR with dilated root at 3.9cm and 4.7cm at the ascending aorta, subsequent angiogram also revealed proximal LAD 60% lesion at the D1 bifurcation with a FFR of 0.81 which is considered significant.
>
> I have discussed the findings with Petar today and the prospect of requiring CABG in addition to SAVR and ascending aorta replacement. He seemed hesitant regarding the surgery as his last AAA operation required about 3 months for him to recover although his stay in hospital was about 1 week. I have also discussed with Petar about mechanical and tissue valves given his age and prospect requiring warfarin and potential risk for valve degeneration that may require further surgery respectively. Petar seemed overwhelmed with the information given today and wanted to have further discussion with his wife and children about this procedure. We have informed him to re-contact us next week should he decide to go ahead with the operation and valve type and we can arrange to see him again in the POAC clinic to discuss further arrangements.

20 There is no separate record of Mr Josipovic contacting the CTSU to advise that he wanted to proceed with the surgery, however I find that he did so because on 21 June 2023 his name was added to the surgery waiting list.[23] That was also the date when the CTSU coordinator, Maryanne Duggin, emailed Mr Josipovic with his appointment time at the pre-operative assessment clinic.[24] The Court heard that this appointment would have been triggered by Mr Josipovic advising of his intention to proceed with surgery.[25]

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18 T283
19 T292
20 Exhibit C23 at [16]
21 Exhibit C7 at 23
22 See Exhibit C7 at 35
23 Exhibit C25, see 'date added'
24 Exhibit C16
25 T456

Pre-operative assessment clinic

21 Mr Josipovic attended the pre-operative assessment clinic on 6 July 2023 and was seen by cardiothoracic pre-operative assessment nurse consultant, Dianne Thompson, and cardiothoracic resident medical officer, Dr Varman Gunasaegaram. Both gave evidence during the inquest. Ms Thompson explained that the pre-operative assessment sessions are run two days a week on Tuesday and Thursday afternoons. Patients are usually seen in the clinic about two weeks before their surgery.[26]

22 During this consultation, Ms Thompson conducted vital signs observations of Mr Josipovic and recorded them in the SA Health electronic medical record (EMR). Dr Gunasaegaram double-checked Mr Josipovic's medical history, confirmed his medications and allergies, and performed a physical examination. Dr Gunasaegaram had access to the EMR which contained records from Mr Josipovic's medical history, including the recent angiogram results which had been scanned in on 1 June 2023.[27] Routine blood testing was ordered. Dr Gunasaegaram also checked the paperwork to ensure Mr Josipovic was ready for surgery.[28] The clinic note on the EMR records that a dental review was to be arranged that day.[29] Mr Josipovic also signed the surgery consent form during this consultation.[30]

23 Dr Gunasaegaram told the Court that he 'very briefly and vaguely' recalled Mr Josipovic attending the pre-operative clinic.[31] He recalled that Mr Josipovic was short of breath, but not in acute respiratory distress.[32] His note on the EMR recorded a date of operation of 14 August 2022, the year 2022 being a typographic error.[33] Dr Gunasaegaram told the Court that he would have taken that date from a piece of paper that he was given before the pre-admission clinic containing the name of the surgeon on the top and the date of the surgery.[34]

24 Mr Josipovic was provided an information booklet which contained a disclaimer about the possibility of surgeries being cancelled and rescheduled.[35]

25 Following the appointment,[36] Dr Gunasaegaram arranged for a further test to be conducted on the pre-existing blood sample, which had returned a positive result for hepatitis B surface antigen, indicating either immunity, exposure or chronic presence. The results of this further testing confirmed that Mr Josipovic was positive for hepatitis B. Dr Gunasaegaram accessed these results on 20 July 2023 and discussed the matter with the gastroenterology registrar, Dr Peter, and with Mr Josipovic himself.[37] Having satisfied himself that there was no need for urgent action, Dr Gunasaegaram referred Mr Josipovic for gastroenterology follow-up to ensure that there were no signs of liver

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26 T209
27 Exhibit C12 at 91
28 T104
29 Exhibit C11c at 140 v
30 T211 and Exhibit C7 at 21
31 T103
32 T104
33 T105
34 This piece of paper could not be located
35 Exhibit C11c at 133 and Exhibit C21 at 6
36 Likely 12 July 2023; T127
37 T109

damage from the chronic hepatitis B.[38] Dr Gunasaegaram ordered bloodborne precautions intra-operatively.[39]

26 The dental review was completed on 17 July 2023.[40] The consultation with Dr Peter on 20 July 2023 in relation to the liver concluded the pre-operative investigations, and from this point in time Mr Josipovic was ready for surgery. While Nikica Josipovic expressed concern regarding the piecemeal fashion in which the pre-operative investigations were undertaken,[41] neither Professor Smith nor Dr Hardikar were critical of the time taken from the onset of symptoms to being ready for surgery.[42] It is important to reflect that cardiac surgery of the type contemplated for Mr Josipovic is serious. It is important for all considerations to be carefully assessed and any potential issues identified and mitigated. It is important that separate speciality opinions are provided in relation to each potential risk factor. I therefore make no criticism of the time it took to ensure Mr Josipovic was ready for surgery, nor of the fact that it contained numerous steps.

27 Two days after the pre-operative assessment clinic on 6 July 2023, Mr Josipovic attended the Emergency Department at TQEH complaining of gastrointestinal-abdominal pain.[43] In light of Mr Josipovic's previous abdominal aortic aneurysm, a vascular cause was investigated and ruled out. The notes from this attendance record that Mr Josipovic was upset in relation to the wait time and wanted to leave before his scan but was persuaded not to do so. It appears that he attended at 11:28 am and was discharged at 7:05 pm. A further CT angiogram was performed during his assessment on 8 July 2023.[44] At this time, the dilatations observed were said to be stable when compared to the 1 May 2023 CT scan. There was no evidence of aortitis or new acute aneurysm.

28 Dr Hardikar told the Court that he thought that Mr Josipovic's abdominal pain may have been related to heart failure or to Mr Josipovic's previous aneurysm.[45] However, Professor Smith said that it was unlikely to be related to deterioration of heart function and he would not expect this presentation to have prompted an advancement of the planned date for surgery.[46] Dr Viana agreed.[47]

29 In light of that evidence, I did not explore this attendance at inquest further as it appears not to have had any contribution to Mr Josipovic's death.

Initial scheduling of surgery

30 Aside from Nikica Josipovic, all witnesses who gave evidence during the inquest understood Mr Josipovic's first scheduled surgery date to be 14 August 2023.[48] Nikica Josipovic gave evidence that the first surgery date was 31 July 2023. He explained that this belief was based on information provided to him by his father. He recalled the date as being 31 July 2023 as it was the same date on which his son was scheduled to have

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38 Exhibit C15 at 6
39 Exhibit C11c at 140
40 T329
41 T64
42 T366 (Hardikar), T594 and T604 (Smith)
43 Exhibit C12 at 30
44 Exhibit C12 at 11
45 T394; Professor Smith agreed that this was a possibility; T605
46 T605 and T651-T652
47 T539 and T541
48 T196

grommets inserted into his ears, and he had a record of this date on his mobile phone.[49] He did not believe he could have been confused about the date, as he had arranged his personal affairs to accommodate it.[50]

31 There was no reference to a 31 July 2023 surgical date within the medical records. In the usual course of events, this might imply that there was never a surgery date set for 31 July 2023, as one might expect a date of such significance to be recorded somewhere within hospital records. However, it became apparent during the inquest that the EMR alone is not a complete or definitive record, particularly in relation to scheduling matters. I am not critical in saying this, it is merely an observation that, like many workplaces, there is more than one place that important information is held. The ascertainment of key dates for Mr Josipovic's journey was not as simple as printing out the EMR.

32 Mr Josipovic's hardcopy CTSU file was produced to the Court and was received into evidence.[51] The front of the CTSU folder listed dates for surgery, struck out upon their cancellation in Mr Josipovic's case, and other notes of contact with Mr Josipovic which were not entered into the EMR.[52] However, the date that Mr Josipovic's name was placed on the surgical waiting list did not appear within the EMR, or within the hardcopy CTSU file. That information was recorded only on the cardiothoracic wait list spreadsheet, which was received into evidence as Exhibit C25.[53] In that light, I am unable to draw any inferences from the absence of the date of 31 July 2023 from the medical notes produced.

33 I note in passing that I heard evidence that handwritten documents are now scanned into the EMR, creating a more complete record in that system.[54]

34 Ms Thompson's evidence was that patients were usually seen in the pre-operative assessment clinic between two and four weeks prior to their scheduled surgery date, and Mr Josipovic's assessment on 6 July 2023 could therefore indicate that an earlier surgery date had been given.[55] However, Ms Thompson gave evidence that she would not have been surprised if Mr Josipovic's surgery was not first scheduled to occur until 14 August 2023, despite the 6 July 2023 clinic date, 'especially because it was a Dr Viana patient' as he was active in the management of his own lists.[56]

35 The Court heard that Dr Viana assumed responsibility for the scheduling of his surgical list. He also triaged referrals directed to him personally. He told the Court that Mr Josipovic would not have been given any date for surgery on 13 June 2023 as he had not yet decided to proceed.[57] Dr Viana did not believe he would have provided a tentative date to Mr Josipovic or otherwise advised that the date of 31 July 2023 was available until it was confirmed that he wanted the surgery, although as I have observed he said he had no specific recollection of the consultation.

36 In light of the conflicting evidence and the lack of clarity, I am not able to conclude with any certainty whether there was a date scheduled for 31 July 2023. If Nikica Josipovic

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49 T84
50 T85
51 Exhibit C15a
52 See, for example, the note dated 11 August referring to Mr Josipovic's response to his surgery cancellation 'patient upset changed to Sept'; Exhibit C15 at 1
53 This date was also referred to in the team based review, Exhibit C2a: '*21/06/2023 – Patient placed on theatre wait list (category 1 – surgery within 30 days*'
54 T305
55 T237
56 T219
57 T524

had been advised of this directly, I would have more confidence in his assertion, however, given the lack of record and Dr Viana's assertion that he would not have assigned any date, I am unable to conclude that Nikica's impression from Mr Josipovic actually reflected the reality of what was objectively intended.

37 I do observe that the inability to be sure about something as simple as the first surgery date scheduled speaks to an inadequacy of record keeping systems that has the potential to give rise to many issues in the day-to-day workings of a busy surgery practice.

38 In any event, the evidence is clear that by the time of the pre-operative assessment session on 6 July 2023, the intended surgery date was 14 August 2023 and this had likely been scheduled by Dr Viana.[58]

39 According to the SA Health policy 'Elective Surgery Access and Management' approved on 6 December 2022, a patient must be categorised as per the National Elective Surgery Urgency Categorisation Guideline (the Guideline) to ensure they are treated in a timely, equitable and clinically appropriate manner. A category 1 is assigned to procedures that are clinically required within 30 days, whereas a category 2 is assigned to procedures that are clinically required within 90 days.[59] Dr Viana assigned Mr Josipovic a category 1 surgical priority.[60]

40 Dr Viana explained that he did not believe Mr Josipovic was a straightforward category 1. He referred to the Guideline, which suggested that the usual urgency for a heart valve replacement would be category 2.[61] Dr Viana explained that he believed it would be safe to perform Mr Josipovic's surgery within six to eight weeks of his assessment on 13 June 2023.[62] Dr Viana said that he had not expected Mr Josipovic to deteriorate as acutely as he did.[63] Nevertheless, he explained that he assigned a category 1 as he thought a category 2 wait time of 90 days was too long.[64] He was uncertain what it was that caused him to feel uncomfortable about assigning a category 2 and speculated that perhaps he was aware of Mr Josipovic's presentations to TQEH. Alternatively, he thought that he may have been concerned that the mild aortic dysfunction and mild left ventricle dilation signified that Mr Josipovic's heart was no longer coping with the amount of aortic regurgitation.[65] Whatever the reason, I am satisfied that Dr Viana considered Mr Josipovic's procedure to be more urgent than the usual heart valve replacements, but not of any extreme urgency.

41 Dr Hardikar and Professor Smith told the Court that they would have assigned Mr Josipovic a category 1.[66] In light of the expert evidence and Dr Viana's explanation, it was entirely appropriate for Mr Josipovic to be assigned category 1.

42 In light of my finding that category 1 was appropriate, and the 30 day requirement that accompanies that category, I turn to consider the selection of the initial date assigned. When the initial date was assigned (14 August 2023), there were more than six weeks

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58 T528
59 Exhibit C9 at 2
60 T550
61 Exhibit C22 at 7
62 T550, Professor Smith agreed that 6-8 weeks would be appropriate if Mr Josipovic was under close surveillance; T587
63 T550
64 T517
65 T518
66 T367 (Hardikar), T595 and T604 (Smith)

before the procedure. However, the Guideline states that patients should only be scheduled for surgery once they are deemed 'Ready for Care' which is defined as when the patient is ready to be admitted for surgery. There is good reason for that, including avoiding slots being assigned for patients that do not achieve readiness in time, resulting in slots being wasted. In explaining the date initially given, Dr Viana relied on this provision together with the fact that heart valve replacements are usually category 2. Under the Guideline approach, Mr Josipovic's surgery was not mandated until 20 August 2023.

43 Dr Viana said that he preferred to add patients to the waiting list before they were ready for surgery, but with a longer date to allow for preparations. He explained:

> It's not unusual for us to provide a tentative date and find out important issues that delay that tentative date of surgery for clinical reasons; the patient is not ready for care. We provide a tentative date for surgery to get things rolling, to not waste time, to activate the pre-admission clinic, to get the dental - dentist, give the patient an opportunity to choose their dentist, so to get the ball rolling. We provide a tentative date of surgery before he is definitely ready for care. [67]

44 Professor Smith said that this is not an uncommon approach in his practice location of Victoria.[68]

45 I make no criticism of Dr Viana's initial scheduling of Mr Josipovic for 14 August 2023. While it was longer than the suggested timeframe for a category 1 patient following scheduling, it was not markedly so and Dr Viana's explanations were reasonable enough. Putting Mr Josipovic onto the waiting list earlier, but with a longer timeframe to allow for final investigations, was at least an acceptable manner of scheduling his procedure. In that light, it is very difficult to find criticism for Dr Viana not waiting until Mr Josipovic was fully ready for surgery and then listing his procedure with 30 days, particularly when that would have resulted in a later date actually being assigned. Had Dr Viana scheduled Mr Josipovic for surgery within 30 days of the date he first put him on the waiting list (6 July 2023), that surgery would have been 5 August 2023; nine days prior to what was scheduled, however that is not what the Guideline allows for and doing so would have run the risk of Mr Josipovic not being ready for surgery and the schedule slot being wasted. If that occurred, a re-schedule would have resulted in an even later surgery date for Mr Josipovic.

Notification of deterioration

46 The next recorded contact between Mr Josipovic and the CTSU was on 31 July 2023, when Mr Josipovic telephoned the CTSU and spoke with Ms Thompson. A note of this conversation was entered onto the EMR on 11 August 2023 likely on the basis of handwritten contemporaneous notes.[69] It read:

> 31/7/23 - contacted by patient reporting that he is 'not in good condition these days' - advised to seek medical attention if required and recent bloods reviewed by CTSU RMO who also rang the patient to discuss. [70]

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67 T473
68 T574
69 T163-T164
70 Exhibit C11c at 133

47 There was no evidence that any arrangements were made by the CTSU to review Mr Josipovic in person to assess his clinical condition and review the urgency of his surgery as a result of the information he provided to Ms Thompson and the resident.

48 Given that Mr Josipovic was calling the CTSU, it is reasonable to infer that he was reporting issues relevant to his upcoming surgery. During inquest, the issue of this conversation and whether it should have prompted any action was explored.

49 Ms Thompson did not record her conversation with Mr Josipovic on the EMR until 11 August 2023. She agreed that she may have been prompted to make this note as a result of the Friday morning meeting on 11 August 2023 when Mr Josipovic's surgery was cancelled.[71] She appropriately conceded that if someone were to speak to Mr Josipovic between 31 July 2023 and 11 August 2023, they might not have been aware of her conversation with him in which he reported his concern of his deteriorating condition.[72] She accepted that the note should have been made on the EMR promptly. Nevertheless, she was confident that Mr Josipovic's surgery of 14 August 2023 was not cancelled in ignorance of her conversation with him as she would have 'spoken up' at the meeting.[73] She clearly had a memory of the call since she was able to make her electronic note. If she did raise this concern at the time the surgery was cancelled, Dr Viana had no recollection of it[74] and there was no documentary evidence in support of her having done so.

50 In the end, I am not critical of Ms Thompson's note being entered late. It was reasonable for her to assume, after having given advice to do so, that any serious deterioration in Mr Josipovic's condition would have resulted in a formal interaction with the health system that would be brought to the CTSU's attention if it was relevant.

Content of the conversation

51 Ms Thompson told the Court that she had no independent recollection of the conversation on 31 July 2023 but assumed it occurred by phone.[75] Consequently, her evidence was limited to her interpretation of the notes she made on the EMR, informed by her usual practice.[76] By necessity, she engaged in a process of reconstruction to explain what she believed she would have said and done.

52 Ms Thompson believed that Mr Josipovic would have spoken the words 'not in good condition these days' as it was not the kind of wording that she would usually use. Further, this was quoted within her note which supports this inference.[77] Ms Thompson acknowledged that her description in the short note of what Mr Josipovic was reporting was very vague and lacked the necessary detail for the surgeon responsible for his care to understand whether his condition had changed.[78] However, it is important to understand that Ms Thompson caused a review of the situation by a resident. That is, while she recorded a brief note about the interaction, she then went about arranging for a doctor to

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71 T228
72 T226
73 T229, Dr Hardikar believed she would have mentioned this conversation on Friday 18 August as he considers her to be very particular and diligent: T399
74 T532
75 T163
76 T223
77 T224
78 T183

speak to Mr Josipovic directly. In that light, I do not find that Ms Thompson should be criticised for keeping the note brief. If she had not acted on the information, I would have found criticism.

53 Ms Thompson explained that her usual advice to patients over the phone who report health issues is to tell them she cannot assess them over the phone and that they should attend the closest Emergency Department or their GP, or call an ambulance depending on the severity of their symptoms. She explained that this resulted in her recording 'advised to seek medical attention if required'. She said that she would ordinarily refer a patient to the Emergency Department first, and if they appeared reluctant to follow that advice, she would encourage them to visit their GP.[79] Ms Thompson agreed that if she directed Mr Josipovic to call an ambulance, she would have made a specific note about that.[80] Ms Thompson could not recall exactly what she said to Mr Josipovic,[81] but she did have a vague memory that Mr Josipovic was quite reluctant to attend emergency again.[82] This accords with the records of his attendance at the Emergency Department on 6 July 2023 when he was upset at the delay and reluctant to stay for long enough for a full assessment. There is no record of Mr Josipovic attending any Emergency Department again until 24 August 2023.

54 Given that, it is likely that Ms Thompson encouraged Mr Josipovic to see his GP. Mr Josipovic had in fact attended his GP, Dr Chaudhary, the previous day.[83] The notes of this consultation are brief in relation to his general condition, as the focus appeared to be on his blood test results and tenderness in the area of his lumbar spine.

55 Professor Smith gave evidence about this interaction. He said that Ms Thompson needed to be '… pretty forceful, and to say that: you'll be assessed, you could well be admitted to the hospital, and your surgery may even be brought forward'.[84] Professor Smith also stressed the importance of explaining to the patient the implications of remaining at home, namely that their condition is likely to get worse.[85] He said that Mr Josipovic should have been advised to attend the Royal Adelaide Hospital specifically, and to come prepared. It was Ms Thompson's evidence, on the other hand, that she would direct patients to their *closest* Emergency Department.[86] While Professor Smith had good reason for his position, I am unable to criticise a nurse for advising a patient in distress to attend their closest hospital.

56 It is unknown what Mr Josipovic might have done if Ms Thompson was more forceful or gave different advice. Submissions were made on the topic of whether advice to Mr Josipovic that attending hospital might result in earlier surgery might have been of assistance.

57 The evidence established that there is no specific written guidance about how concerned patients on the surgical waiting list should be dealt with, but it was clear that Ms Thompson was adequately prepared to provide sound advice. It may be helpful for

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79 T225
80 T235
81 T174 and T184
82 T234
83 Exhibit C4 at 28
84 T625-T626
85 T628
86 T225

there to be a protocol requiring any issues to be raised with the surgeon. I will consider that later when I turn my attention to the question of recommendations.

Medical review

58 In terms of the action she took in response to the call, Ms Thompson surmised that she would have made a handwritten note of the conversation on the CTSU file, taken it down to the ward for her note to be actioned, then returned the following day to collect the file.[87] Unfortunately, there was no handwritten note on the CTSU file produced to the Court.

59 Ms Thompson interpreted her note 'recent bloods reviewed by CTSU RMO who also rang the patient to discuss' to mean that after her conversation with Mr Josipovic, she asked the CTSU resident to review the blood test results and to call Mr Josipovic to discuss his symptoms.[88] She said the note did not relate to any previous occasion of contact about blood test results.[89] She told the Court that she believed she had a recollection of going down to the ward to ask a resident to review the blood test results, but said that she could not definitively say this occurred as it was not unusual for her to speak to residents.[90] I find that Ms Thompson's clear note that this occurred is sufficient to establish that she did raise Mr Josipovic's call with a doctor.

60 There was no note on the EMR from any resident on 31 July 2023. Dr Gunasaegaram told the Court that he was unaware of this call from Mr Josipovic.[91]

61 It was Ms Thompson's evidence that she is unlikely to have reported this conversation with Mr Josipovic to Dr Viana on the day that it occurred, possibly as he was not present. She explained that if she had updated Dr Viana, she would have made a note 'Viana updated'.

62 Professor Smith's opinion was that Mr Josipovic's call should have prompted a face-to-face review on 31 July 2023 or soon afterwards. He explained that this was required as worsening symptoms in the context of aortic valve regurgitation should have rung alarm bells of a significant deterioration in cardiac function.[92] Having read the transcript of the evidence of Ms Thompson, Professor Smith maintained this view.[93]

63 Professor Smith opined that an echocardiogram would likely have been performed if Mr Josipovic had been clinically assessed following this conversation,[94] particularly as he had not undergone an echocardiogram since March 2023. This non-invasive investigation would have taken approximately 30 minutes[95] and provided clear information about the functioning of Mr Josipovic's heart at that time. This information would have been relevant to determining the clinical urgency of surgical intervention and may have warranted reconsideration of the scheduled date for surgery. Professor Smith said in his report that, by this stage, Mr Josipovic should have been promptly seen in the next outpatient clinic because he most likely required admission to hospital and expedited

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87 T163-T164
88 T175
89 T177
90 T178 and T225
91 T115
92 Exhibit C26a at 2
93 T625, Professor Smith did not regard the blood test results viewed by Ms Thompson on 31 July as alarming; T629
94 T640-T641
95 T634

surgery as an inpatient,[96] however, in my view, that situation is crystallised with the benefit of hindsight and it is much less clear that such an approach was mandatory on the information known to those involved at the time. In his oral evidence, Professor Smith explained that he had not been made aware of the nature of the outpatient clinic at the time and that, in fact, referral to the Emergency Department was the preferrable course.[97]

64 Dr Viana also opined that a vague report such as the words 'not in good condition' would require a proper medical assessment to determine the significance of the complaint. Dr Viana spoke about the 'domino effect' of re-reviewing patients who not infrequently call in and report deterioration.[98] He observed that some of these are acutely unwell and others are not.

65 The Court heard evidence from several witnesses that the CTSU clinic did not and still does not have capacity to review patients awaiting surgery, even if their surgery was scheduled to occur after the expiration of the nationally accepted waiting time for their category.[99] Ms Thompson explained that if the clinic were to review such patients it could result in the entire clinic schedule being filled without assessing any new patients.[100] Ms Thompson explained that even three additional patients a week could not be accommodated.[101] Ms Thompson said that referral back to a clinic would simply not be the pathway adopted if a patient had already been through the clinic.[102] I do not consider that referral to the clinic again was the only way to deal with Mr Josipovic's call and I make no criticism of Ms Thompson for not arranging for Mr Josipovic to be reviewed in the CTSU clinic. It simply was not an option.

Relevance to scheduled surgery

66 Dr Viana could not recollect having a conversation with Ms Thompson about the call, but said that it could have been raised with the surgeon on-call, or any other surgeon, in his absence, and he would expect that to have occurred in accordance with usual practices.[103] Had he been provided with this information himself, he said that he would have confirmed that the patient was instructed to seek medical attention at an Emergency Department, and then flagged the patient on the waiting list to potentially not be considered for cancellation if cancellations were needed.[104]

67 After carefully assessing this event, I am satisfied that Mr Josipovic's phone call to Ms Thompson on 31 July 2023 was a missed opportunity to review his clinical condition and obtain vital information regarding the urgency of surgical intervention as compared with the other patients on the waiting list. Had an echocardiogram been performed in response to his complaint of worsening condition, it would likely have revealed the unexpectedly swift progression of his aortic regurgitation and potentially resulted in an earlier date for surgery.[105] Importantly, as suggested by Dr Viana, it may have prevented his surgery of 14 August 2023 from being cancelled, as the relative urgency of surgical

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96 Exhibit C26a at 2
97 T679-T680
98 T477
99 T174, T229 (Thompson), T312, T344, T403-T404 (Hardikar), T446, T447, T477, T495 and T544 (Viana)
100 T229
101 T236
102 T174
103 T475
104 T476
105 Professor Smith expressed the view that the progression of Mr Josipovic's aortic regurgitation was accelerated, and this should have been known by the surgeon if they reviewed the echocardiograms; T643

intervention would have been known. However, in making that finding, I also find that the loss of this opportunity was not brought about or contributed to by any of the clinicians involved. What was required was for Mr Josipovic to attend an Emergency Department and report his complaint as he had been advised to do by Ms Thompson. I find that this would likely have led to an echocardiogram or other testing which was likely to have raised concern that was fed back to the CTSU. This was, in turn, likely to have been taken into account when making decisions about scheduling, which I will discuss next.

Cancellation of the first surgery

68 Ms Thompson explained that planning meetings occur each Friday morning, and are attended by all of the cardiothoracic consultants and cardiothoracic registrars, and often the anaesthetists.[106] The ward nurse unit manager and the intensive care unit manager are also in attendance.[107] While the planning meetings were attended by assorted medical staff, decisions regarding the scheduling of surgery were within the remit of the consultants.[108]

69 Mr Josipovic's 14 August 2023 surgery was cancelled on 11 August 2023 during the Friday morning planning meeting. Ms Thompson, Dr Sam Emmanuel, Dr Hardikar, and Dr Viana were present at the meeting on 11 August 2023.[109]

70 Dr Viana told the Court that he attended the 11 August 2023 meeting and recalled that those present considered the surgical calendar for the week of 14 August 2023 and observed that the large majority comprised inpatients.[110] He explained that inpatients are prioritised for clinical reasons and for 'bed-flow' reasons.[111] He said that this particular week had an unusually high number of cancellations.[112] In that week, nine elective surgeries were cancelled as well as one inpatient surgery. This includes the surgery for Mr Josipovic.[113] Of those surgeries, at least six were cancelled because of inpatient surgeries.[114] Two were cancelled at the patients' request and one was referred to cardiology. The records therefore establish that Mr Josipovic's surgery was cancelled due to prioritisation of inpatient cases.

71 Dr Hardikar said that each of the patients who had surgeries that proceeded that week were either inpatients or otherwise were category 1 patients with lung cancer.[115] Each of these patients were considered to have a higher urgency for their surgery to proceed than Mr Josipovic. It is not always the case that an inpatient will have a higher urgency than an outpatient and clinical assessment is made of the individual circumstances. However, a relevant consideration is that an inpatient whose procedure is postponed will result in the use of a hospital bedspace for longer which will have a cascading effect that works backwards to create less availability of intensive care spaces for post-operative patients and less capacity for surgeries.[116] It is also generally true that inpatients will be more

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106 T145
107 T146
108 T146
109 T146, T399 and T532
110 T532
111 T482
112 T481
113 T192
114 T194
115 T337
116 T271

unwell than those remaining in the community. Professor Smith said that the general preference for priority to inpatients to achieve bed-flow is appropriate.[117]

72 Dr Hardikar lamented in relation to the postponements that 'the same story repeats every week unfortunately',[118] and that the prior week, they had also cancelled seven patients.[119] He told the Court that he considered Mr Josipovic's case to be the 'tip of the iceberg' in relation to scheduling issues.[120] He explained that for a cardiac surgery to occur, there needs to be a bed available in the Intensive Care Unit, which can create difficulty given that the number of beds was reduced from 24 to 16 following the move to the new Royal Adelaide Hospital.[121] He said that investigations were underway for a flexible capacity model which could provide the additional 20% theatre capacity he estimated was required to deal with demand.[122] In terms of the obstacles to this model, Dr Hardikar stated that the main issue has been funding.[123]

73 In light of the general issues facing the CTSU and the specific patients that were prioritised that week, I find that there is no criticism to be made of the decision to postpone Mr Josipovic's surgery on the basis of the information that was known at the time.

74 Mr Josipovic was informed on that Friday that his surgery had been rescheduled to September.[124] A handwritten note on the front of the CTSU folder dated 11 August 2023 reads 'Pt upset changed to Sept. S.O.B worse feels like he's coughing'. The date of '14/8/23' was struck out and replaced with the date of '11/9'. The cardiothoracic surgery wait list,[125] was also updated to reflect a new surgery date of 11 September 2023. Dr Viana explained that Mr Josipovic's surgery had been temporarily 'parked' on 11 September 2023, which was his next available date. He said it was not formally scheduled for that date,[126] which he acknowledged would always have been too far away.[127] This date was therefore essentially a placeholder until an earlier date could be found. Dr Viana agreed in principle that given Mr Josipovic's clinical presentation, it was preferrable not to reschedule his surgery at all. However, he explained that the CTSU was doing everything possible with the resources that they had at the time.[128]

75 On 18 August 2023, Mr Josipovic attended the Royal Adelaide Hospital for an iron infusion.[129] Professor Smith reviewed the vital sign observations recorded at this time and gave evidence that he considered they suggested that Mr Josipovic was not in heart failure at that time.[130]

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117 T607-T608
118 T337
119 T338
120 T355
121 T236 and T363
122 T362
123 T363
124 Exhibit C15 at 1
125 Exhibit C25
126 T333
127 T479
128 T486
129 Exhibit C7 at 7-9
130 T634

Cancellation of the second surgery

76 The temporarily parked September date was revised to 22 August 2023, only a week after the first scheduled date. Dr Viana told the Court that he was unaware who made this decision, but that he understood it to be a response to the information provided to Ms Thompson on 31 July 2023.[131] Dr Hardikar recalled that he offered to do the surgery as Dr Viana had a full schedule until September, and he had an available slot on 22 August 2023, given that he had only recently joined the CTSU.[132] This would avoid the need for Dr Viana to cancel a different patient in lieu of Mr Josipovic. Dr Hardikar had attended the Friday planning meeting, notwithstanding that he was on leave at the time. Dr Hardikar said that it was not unusual for another surgeon to take over a case where capacities shifted. In that sense, the CTSU was working as a team to achieve as many procedures as possible.

77 Mr Josipovic was advised of this new date on 17 August 2023, with short notice before the newly scheduled date.[133] However, the relief that would have accompanied the news was to be short-lived.

78 Unfortunately, the new surgical date was also subsequently cancelled.[134] Dr Hardikar explained that he was on-call on the weekend and he cancelled Mr Josipovic's surgery due to a newly arrived inpatient with acute coronary syndrome who was experiencing ongoing heart attacks.[135] The other two cases listed for that day were also inpatients with acute coronary syndromes, and therefore considered of a higher priority.[136] Dr Hardikar frankly said 'angina trumps shortness of breath'. Professor Smith reviewed the information about the competing priorities and concluded that it was reasonable to place Mr Josipovic as at a lower priority than the other patients.[137] In light of the evidence I heard about the prioritisation done on the information as was known at the time, I find that the cancellation of this re-scheduled surgery was not an unreasonable decision. In the end, the scheduling of a date for Mr Josipovic quickly was likely too ambitious and while appropriately attempted, was not able to be achieved.

79 Dr Emmanuel contacted Mr Josipovic by phone on Sunday, 20 August 2023 to advise him of the cancellation. Dr Emmanuel made a contemporaneous note of this call,[138] and had a recollection of making that call at the time he gave evidence.[139]

80 The note read as follows:

> Emmanuel - CTSU registrar
>
> Contacted patient to cancel Tuesday's operation given inpatients requiring urgent coronary surgery
>
> Patient advised he feels he's been deteriorating while at home, with debilitating shortness of breath on background of multiple cancellations previously

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131 T552
132 T331 and T373
133 T197
134 T339
135 T339
136 T339-T340
137 T636
138 Exhibit C5b
139 T246

> Son was on phone call too, likewise stated that patient has been feeling worse and is upset at the multiple rescheduling
>
> I advised the patient and his son that if symptoms are worsening and he feels that he is deteriorating to present to ED for thorough assessment which may change his priority for OT
>
> I will discuss with Dr Hardikar tomorrow regarding prioritisation and new OT timing[140]

81 What the note makes clear is that this was the second occasion that Mr Josipovic had raised concerns of a deterioration with members of the CTSU and this was the second occasion that he was advised to go to the Emergency Department if things got worse.

82 Apart from that, the Court heard conflicting evidence from Dr Emmanuel and Nikica Josipovic in relation to certain aspects of this conversation.

83 Dr Emmanuel said that he told Mr Josipovic's son that his father needed to present to the Emergency Department if he was not coping at home, as he could then be reassessed in terms of his urgency and could even be admitted to the hospital.[141] He explained that he had this discussion about a potential admission after Nikica Josipovic said that Mr Josipovic should not be disadvantaged due to being an outpatient.[142] He said that he recalled discussing Mr Josipovic's previous presentations to TQEH, and recalled that he said 'something to the effect of don't go to TQEH Emergency Department, come to the Royal Adelaide Hospital and we can assess you in person and that may very well change how urgent the operation is…'.[143] This specific direction to attend the Royal Adelaide Hospital was not included in Dr Emmanuel's contemporaneous note, however reference to an increase in priority for surgery is clearly recorded. It logically follows that this assessment was envisaged to occur at the Royal Adelaide Hospital, as this would be the only place where those that could make such a re-assessment were. I also consider it unlikely that if Dr Emmanuel was contemplating a potential admission, that he would advise Mr Josipovic to go anywhere other than the hospital where the procedure was intended to be performed.

84 Nikica Josipovic recalled this advice differently, stating that the caller simply said to present to the Emergency Department if his father felt he was deteriorating, and that was the extent of the advice.[144] He was certain that the caller did not say that presentation for assessment might change his priority for an operating time.[145] I find that this advice was given. I place significant weight on the fact that not only did Dr Emmanuel recall saying this, but he had also made a contemporaneous note to that effect. It appears that Nikica Josipovic did not appreciate what had been said.

85 Dr Emmanuel recalled that he was told by Mr Josipovic's son that he was reluctant to go to the Emergency Department, as he felt the assessments there were inadequate, and the wait times were too long.[146] This is, once again, consistent with the notes from Mr Josipovic's July admission to TQEH where he expressed similar thoughts.[147]

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[140] Exhibit C11c at 151
[141] T247
[142] T247
[143] T247
[144] T90
[145] T90
[146] T248-T249
[147] Exhibit C12 at 30

Dr Emmanuel explained that he did not consider referring Mr Josipovic back to the pre-operative assessment clinic due to its limited capacity. He said that triaging in the Emergency Department leads to a quicker assessment, rather than 'wast[ing] a few more days for a time in an outpatient department'.[148] Consistent with his note, he says that he did not tell Mr Josipovic or his son that if they went to the Emergency Department the surgery date would definitely be brought forward, but he says that he promised a reassessment would take place.[149]

86 Dr Emmanuel was confident that he explained to Mr Josipovic's son the difference between presenting to TQEH, which does not have a cardiothoracic team, and presenting to the Royal Adelaide Hospital, which does.[150]

87 Dr Emmanuel recalled having a conversation about Mr Josipovic with Dr Hardikar the following day, however he did not make a note of this discussion.[151] Dr Hardikar also recalled this conversation. He recalled that Dr Emmanuel told him Mr Josipovic was becoming 'more short of breath', and that Mr Josipovic had requested that the operation not be cancelled.[152]

88 Dr Hardikar recalled being told by Dr Emmanuel that he had told Mr Josipovic to attend the Emergency Department. When Dr Emmanuel told him that Mr Josipovic expressed a reluctance to re-attend the Emergency Department, Dr Hardikar said to Dr Emmanuel 'Then tell him to come to the Royal Adelaide Emergency Department'.[153] He said that he told Dr Emmanuel to call Mr Josipovic again to tell him to come to the Royal Adelaide Hospital.[154] Dr Emmanuel recalled this advice all being given in one phone call.

89 In my view, if it is accepted that Dr Emmanuel told Mr Josipovic that attendance at the Emergency Department would allow a reassessment of the surgery date, then it must be accepted that the advice was to attend at the Royal Adelaide Hospital. If it were otherwise, then such a reassessment would not have been possible. Dr Emmanuel said he had a clear recollection of that topic being discussed.[155] Notwithstanding that this level of granularity was not included in Dr Emmanuel's note, and that Dr Hardikar thought there might have been a second call, I find, on the balance of probabilities that Dr Emmanuel counselled Mr Josipovic to attend at the Royal Adelaide Hospital if he felt he was worsening.

90 Another dispute about this event was Nikica Josipovic's evidence that he had told Dr Emmanuel that Mr Josipovic would not survive until the next surgery date. Dr Emmanuel said that he could not recall being told that.[156] Dr Hardikar gave evidence that he was not told that this had been said and that, if he had been made aware of this, he would have escalated the matter to make sure that Mr Josipovic was reviewed, or at the very least, that a phone call was made to follow up and see how he was doing.[157] While this is likely to be a particularly traumatic aspect of Mr Josipovic's death, it is unclear to

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148 T250
149 T263-T264
150 T268
151 T252
152 T341
153 T402
154 T402
155 T277
156 T275
157 T403, Dr Emmanuel did not recall this being said: T275

me what a doctor should reasonably be expected to do with a prognosis provided by a family member who is not medically trained other than to suggest that the patient present for assessment. If Nikica Josipovic made this comment, which I am inclined to accept he did, I make no criticism for Dr Emmanuel responding to it with the advice and action he did.

91 Professor Smith considered the transcript of Dr Emmanuel's evidence together with his contemporaneous note. He expressed the view that Dr Emmanuel should have been a little more forceful and direct in the advice provided.[158] This was disputed on the basis that the note did not suggest that advice was given softly and that was not Dr Emmanuel's recollection. I accept that there is no evidence of a lack of firm advice. In my view, it is only with hindsight that such a finding could be made. That is, on the information as it was known to Dr Emmanuel at the time, it was reasonable to tell Mr Josipovic to attend the Emergency Department for reassessment of his surgical urgency if he felt that he was deteriorating, and then leave it to him to decide what to do. In my view, a lack of more forceful language is not a matter that requires coronial criticism where the advice actually given was in itself sound. I also do not consider it appropriate to work backwards from the fact that Mr Josipovic did not attend the Emergency Department and conclude that he was not told to do so, particularly in light of his known reluctance to attend.

92 I accept that Mr Josipovic had raised, once again, concerns of deterioration. I also observe that he was again given advice to attend the Emergency Department. There is no record that he did so on that day. Without his physical presence at hospital for the CTSU to assess, it is very difficult to conclude that more should have been done.

93 In any event, the information provided to Dr Hardikar was sufficient to cause him to commence the process of arranging for an additional Friday surgical session to perform the surgery on 25 August 2023.[159] Dr Hardikar explained that when he looked at the schedule, he could tell that all of the remaining patients for the week were category 1 patients who were either inpatients or on heparin infusions and one with infective endocarditis. He therefore formed the view that none of them could be cancelled to facilitate Mr Josipovic's surgery. The solution he devised was to add an additional list for that week. He explained that this involved liaising with a theatre coordinator, finding an anaesthetist who was available, a perfusionist who was available, nurses who were available and checking with the Intensive Care Unit that they could accommodate an additional patient.[160] Dr Hardikar was able to achieve all of this and a new surgical list was stood up for 25 August 2023.

94 The result was that the cancellation of the 22 August 2023 date and the subsequent phone call resulted in a delay of only three days. As I will explain, those three days turned out to be critical. However, that was not to be known at the time and having already found that the decision to cancel the 22 August 2023 date was unavoidable, Dr Hardikar's solution is commendable.

Cardiac arrest

95 The night before Mr Josipovic's most recent scheduled surgery date, that is on 24 August 2023, he experienced a borderline loss of consciousness event and had an acute

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158 T626 and T682
159 T343
160 T343

exacerbation of his shortness of breath. Mr Josipovic's family called an ambulance, and he was taken to the Royal Adelaide Hospital, arriving at 7:09 pm. While in the Emergency Department he experienced an episode of ventricular tachycardia, which led to cardiac arrest. Mr Josipovic was transferred to the Intensive Care Unit at approximately 11:45 pm that night.

96 It became apparent that he may have had an acute ST-elevation myocardial infarction, and his blood had become increasingly acidotic. His clinical picture was thought to raise the potential for subendocardial ischaemia due to free aortic regurgitation.

97 A decision was made to take Mr Josipovic urgently to theatre. Surgery was commenced at 3:19 am by Dr Hardikar. During the procedure, the ascending aorta was replaced due to friable tissue and bleeding. As Mr Josipovic was unable to be weaned off cardiopulmonary bypass, an order was made for Mr Josipovic to remain on central veno-arterial extracorporeal membrane oxygenation (ECMO) for 24 hours. Unfortunately, this resulted in blood clotting, which is a known complication of the use of this strategy.

98 After reviewing the records, Professor Smith concluded that there was no issue with the competency of Dr Hardikar's surgery, nor with the implementation of the ECMO. Professor Smith specifically identified that measures had been taken to prevent blood clotting. I accept Professor Smith's expert clinical opinion and find that the surgery and post-operative care was satisfactory.

99 Unfortunately, notwithstanding appropriate care, the post-operative course was marked by multiple complications which Mr Josipovic was unable to overcome. Mr Josipovic was pronounced life extinct three weeks later at 5:50 am on 14 September 2023 in the company of his wife Finka and son Nikica.

Preventability

100 I accept that the risks involved in cardiothoracic surgery are never nil. Mr Josipovic had serious conditions under investigation as well as other comorbidities. I accept that there is no precision involved. However, I am required to assess the likelihood of Mr Josipovic surviving as matters unfolded.

101 Dr Viana agreed that it would have been preferable for Mr Josipovic's operation to have proceeded as scheduled on 14 August 2023.[161] Dr Hardikar went significantly further and conceded that a lack of access to timely surgical intervention resulted in Mr Josipovic's death.[162] He opined that as of 18 August 2023, the risk to Mr Josipovic's life during surgery would have been between 3-5% based on the EuroScore calculation.[163] The Court heard that the EuroScore calculation is a cardiac surgery risk stratification tool which is an internationally accepted method of ascribing risk. Professor Smith agreed with this assessment.[164] Dr Viana estimated the risk to be slightly higher at 6-8%.[165]

102 In line with this evidence and on the balance of probabilities, it is clear that had Mr Josipovic's surgery on 14 August 2023 not been cancelled, his chance of survival was

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[161] T486
[162] T347 and T407
[163] T347
[164] T635-T636
[165] T485

high. Of course, I observe that proceeding with the surgery on that day might have come at the cost of the chance of survival of another patient and that difficult decisions were made. I am in the end unable to conclude that there was a genuine opportunity to make a different decision.

103 By the time of the emergency presentation on 24 August 2023, Dr Hardikar opined that Mr Josipovic's EuroScore was about 30%. This risk increased to between 50-60% after his cardiac arrest.[166] The difference in survivability is therefore stark as time went on.

104 Professor Smith said that, on the balance of probabilities, Mr Josipovic's death could have been prevented by surgical intervention on or before 22 August 2023.[167] Professor Smith's opinion was informed, in part, by the recorded observations of Mr Josipovic on 18 August 2023 when he attended hospital for his pre-operative iron infusion.[168] Dr Viana did not see Mr Josipovic on this occasion but was later asked to review the vital sign observations with a view to providing the Court with an understanding of his condition at that time. The EMR entry for that day records 'feeling fine today, denies recent cold or flu, with baseline obs taken, vitals within patient's normal limits'.[169]

105 Dr Viana's interpretation was that the observations on 18 August 2023 were consistent with what he would expect from a patient with aortic valve regurgitation, and that the vital signs did not indicate to him that Mr Josipovic was in distress.[170] Professor Smith agreed that the vital signs were acceptable and that they did not suggest the presence of heart failure when viewed on their own.[171] In his view, an echocardiogram and an x-ray would have been required to see how the heart was functioning.[172] However, there was no indication for these to be performed.

106 Having considered this evidence I find that, on the balance of probabilities, Mr Josipovic's death would have been unlikely if surgery was performed on or before 22 August 2023. Once again, I have already assessed the circumstances that led to an inability to conduct the surgery in that timeframe and the efforts made to have it listed as quickly as possible. In light of those findings, I am unable to conclude that there was any genuine opportunity to make different decisions that would have changed the outcome.

107 Professor Smith was uncertain as to whether Mr Josipovic's death could have been prevented if the surgery occurred on 24 August 2023, but prior to Mr Josipovic's cardiac arrest at 9:49 pm.[173] Dr Hardikar said that Mr Josipovic's attendance at hospital *in extremis* created a tenfold increase in risk of death.[174] While there was potential for Mr Josipovic's death to have been prevented if the surgery was performed on 23 or 24 August 2023, I am unable to conclude that this was more likely than not.

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166 T347
167 T649
168 Exhibit C7 at 7
169 Ibid
170 T488
171 T634
172 T634
173 T644
174 T347

Care

108 I wish to record that after carefully reviewing the evidence of each of the witnesses, and the various criticisms raised with them, I was impressed by the witnesses who gave evidence. I have found that Mr Josipovic's death could have been prevented if his surgery was performed earlier, but that the opportunity to perform it earlier did not genuinely arise. I do not make any finding that the decisions that led to the cancellations were the result of ill-will or lack of due care. The medical witnesses are clearly experts in their field and clearly brought a high degree of care and attention to Mr Josipovic's case, in the context of a wider cohort of concerning patients. This was a case where systemic failings of an overworked system resulted in the inability to detect the extent of Mr Josipovic's deterioration before it was too late, potentially contributed to by the fact that he did not attend the Emergency Department on occasions when he was invited to, which will reasonably give clinicians a sense of ease about the seriousness of his deterioration and also prevented the physical examination of his condition that was necessary to fully appreciate his risk.

Public in private

109 During the inquest, I heard evidence that Mr Josipovic's family had the means to, and would have, funded a private surgeon if they had been aware of the likely delay in the public system.[175]

110 The Royal Australasian College of Surgeons has published Guiding Principles for Outsourcing Elective Surgery Waiting Lists in Australia which indicates that such a practice is appropriate, but requires specific considerations to be applied in the implementation of such a practice to ensure both patient safety and continued development of the surgical profession.

111 An affidavit of Nicole Jones, Program Director for Heart and Lung and Specialty Medicine 1 within the Central Adelaide Local Health Network was received into evidence.[176] Ms Jones stated in her affidavit that SA Health has contracts with private health providers, namely St Andrews and Ashford Hospitals, for eligible cardiothoracic patients to be treated as 'public in private' patients.[177] This effectively allows for public funding to be used in private facilities where the private facility is unable to perform a required procedure. This is governed by Guidelines for Public in Private Outsourcing. Under those Guidelines, patients at high risk of morbidity and mortality, defined as patients with a EuroScore above 5% or Society of Thoracic Surgeons risk scores above 4%, are generally excluded from the public in private program, although these Guidelines are said to be not prescriptive.[178]

112 Dr Viana gave evidence that Mr Josipovic's case was not suitable to be undertaken privately due to the risk and complexity of his procedure and due to his previous surgery.[179] Dr Hardikar agreed.[180]

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175 T38
176 Exhibit C23
177 Exhibit C23 at 2
178 Exhibit C23 at NJ-1
179 T485
180 T335-T336

113 Professor Smith, on the other hand, told the Court that the surgery could have been performed in a private hospital when Mr Josipovic presented early on and was placed on the waiting list, and before his condition deteriorated.[181] While he was reluctant to volunteer a precise date, he estimated that the surgery could have been performed privately up until about 21 July 2023.[182] That is, before Mr Josipovic's first scheduled date was cancelled.

114 Given that I have accepted that the initial scheduling of Mr Josipovic's surgery was appropriate, it follows that there was no genuine opportunity for private surgery to have been considered suitable and achieved before it was identified that the public procedure was not going to be completed in time. I observe that Mr Josipovic was not considered ready for surgery until 20 July 2023, one day before Professor Smith considered he was no longer suitable for a private procedure and that, at that time, he still had a scheduled procedure on 14 August 2023 with no sign of needing cancellation.

115 This mechanism was therefore not a genuine opportunity to prevent Mr Josipovic's death.

Improvements following Mr Josipovic's death

116 I heard evidence that, following Mr Josipovic's death, there have been several improvements to the manner of delivery of cardiothoracic services at the Royal Adelaide Hospital.[183] It was apparent to me that Dr Hardikar was deeply affected by Mr Josipovic's death and that he was motivated to use his position to advocate for improvements which might reduce the likelihood of a similar event recurring.

117 Ms Thompson gave some operational insight when she said that as the new Head of Unit, Dr Hardikar is very proactive and involved in reviewing the CTSU processes, and there is now better oversight of the waiting lists.[184] She explained that a waiting list update is sent to staff each week, and each surgeon is individually emailed a list of patients on their waiting list, and identifying those who are overdue.[185]

118 Dr Emmanuel said that more patients who are admitted are now discharged home and brought back to theatre as outpatients so that they do not receive their surgery earlier than higher priority patients merely because they are already occupying a hospital bed.[186]

119 There is also now a second theatre available every second Friday which has increased the capacity for operating, and two new consultants have also joined the CTSU.[187] The combination of an additional theatre day each fortnight and additional surgeons has a great capacity to reduce waiting times generally. The additional managerial oversight of the list will likely lead to identification of patients at greater risk earlier. I accept that these changes have improved overall patient safety. Still, more can be done.

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[181] T653
[182] T655 - T656
[183] See Exhibit C23
[184] T203
[185] T204
[186] T271
[187] T204-T205

120 A couple of slots are now left vacant each week to allow for urgent inpatients to have procedures without this requiring the cancellation of planned patient procedures.[188]

121 Professor Smith was asked to consider three tables setting out the Royal Adelaide Hospital elective surgery waitlist times by month for the years 2023, 2024 and 2025 to the date of the inquest.

122 Professor Smith observed that in August 2023, 13 out of 37 category 1 surgeries were overdue (35%) with an average wait of 11 weeks. The 14 category 1 surgeries performed on time, on the other hand, had an average length of wait of 13.25 days. The result of the data is to establish that where category 1 surgeries are performed within time, they are performed very quickly. Where they are not performed on time, there is significant delay.

123 Professor Smith told the Court that this would not occur at Monash Hospital, and that the concept of category 1 patients waiting 11 weeks for surgery was foreign to him.[189] He speculated that perhaps surgeries were being categorised as category 1 when they were actually category 2, which might have the effect of leading to surgeons and administrators being comfortable with delays to their procedures which are not in truth of category 1 urgency.[190]

124 In August 2024, 29 out of 44 category 1 patients were overdue (66%) with an average length of wait of a little over 7 weeks. This is a noteworthy change over 2023 figures, with a doubling of the number of category 1 patients overdue, but a meaningful reduction in the average time they were made to wait.

125 It was posed to Professor Smith that scheduling patients so far into the future may be the reason why the average wait time is so long, because there is then a need to find another place for a person needing rescheduling in an already full waiting list.[191] In other words, that there was a cascading effect of cancellations. He agreed that this was a very reasonable hypothesis.[192] It is submitted that the long surgical delays for scheduled patients could potentially be reduced by adopting the same process as interstate hospitals where patients are given a wider timeframe and firm dates are not provided until about a week prior to the surgery. This allows for flexibility in filling a schedule with cases that are more likely to proceed, resulting in more output per surgical day and getting through the waitlist quicker.

126 After his examination of the data, Professor Smith suggested that an external review of the entire patient journey, from the referral, the initial appointments and assessment, and then the placement on the waiting list, in addition to the categorising and how the waiting list is administered, should be conducted.[193] He expressed the view that the review should be surgically-oriented, but that it should also include an administrator or other professional who understands the resourcing issues faced by public hospitals.[194]

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188 T294-T295
189 T612
190 T612
191 T623-T624
192 T623
193 T616
194 T616

127 The topic of the economics of such a project was raised. While it is recognised that a review will require the expenditure of public resources, it is clear from the evidence of Dr Hardikar that this would be a cost-effective use of resources. It was his evidence that the total cost of Mr Josipovic's surgery would have been less than $75,000 if it had occurred electively. The ultimate cost of his care following emergency admission was closer to $250,000.[195] The delay in the performance of Mr Josipovic's cardiac surgery exponentially increased the risk to his life and the financial cost to the State. Given that Mr Josipovic's case is the 'tip of the iceberg',[196] it can be safely inferred that a properly conducted external review could assist Dr Hardikar to introduce efficiencies to the CTSU which could be lifesaving and fiscally advantageous.

External review

128 I consider, based on the evidence heard during the inquest, that an external review should consider the following matters:

- The referral process
- The capacity of the outpatient clinic to provide its services in a timely manner
- The utility of a financial disincentive for overdue category 1 surgeries
- The possibility of 'patient swaps' between the Royal Adelaide Hospital and Flinders Medical Centre cardiothoracic units to better spread the load of urgent cases
- The costs and benefits of an additional theatre list
- The adequacy of the physical environment[197]
- The monitoring of patients awaiting surgery
- The process to be followed in the event of surgical cancellations
- The standard of documentation

The referral process

129 During the inquest, it became apparent that the CTSU routinely receives incomplete referrals, which creates not only an administrative burden to the staff who then are responsible for collating the relevant missing information, but more concerningly creates a risk that important information will be overlooked by the surgeon who takes conduct of the case.

130 Professor Smith told the Court that he would expect to see the information that was available to the multidisciplinary team, attached to the referral which would assist in assessing urgency,[198] including documents such as discharge summaries for emergency presentations and previous investigations reports.[199] He would also expect to see medications, social circumstances, findings on clinical examination, scans and

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195 T361
196 T354
197 See T455 (Viana) and T362 (Hardikar)
198 T590
199 T592

investigations already performed, and details of previous Emergency Department presentations.[200]

131 Dr Viana said that it would be helpful if the referral form contained key documents such as reports of cardiac investigations (including echocardiograms, CT aortograms and coronary angiograms), pulmonary function tests, and dental checks.[201] He explained that results of previous echocardiograms in particular can be difficult to source after-hours, and require a telephone call to the cardiologist's rooms.[202]

132 Professor Smith provided the Court with information regarding the referral process at Monash Health, including the 'Request for Elective Admission Form' and the MDT documentation template. He explained that copies of the echocardiogram and the angiogram would be attached and is considered the 'bare minimum'.[203]

133 Given that evidence, the information provided in Mr Josipovic's referral was inadequate.[204] In particular, there was no reference in the referral to the accelerated progression of Mr Josipovic's aortic regurgitation, as evidenced by the comparison of the echocardiograms of February and March 2023, or to his presentations to the Emergency Department of TQEH.

Financial disincentive for overdue category 1 surgeries

134 Professor Smith informed the Court that in Victoria, a financial penalty is imposed on the funding of the public hospital if a patient exceeds the 30-day wait time for category 1 patients. There is a $50,000 penalty imposed per patient who falls outside of this timeframe.[205] At Professor Smith's hospital it is extraordinarily unusual for a patient to exceed this 30-day limit. As current Head of CTSU, Dr Hardikar said that he would be supportive of a financial disincentive for overdue category 1 surgeries.[206]

Improving coordination between Royal Adelaide Hospital and Flinders

135 Ms Jones said that the CTSU are 'working on' the principle of patient swaps between the Royal Adelaide Hospital and Flinders Medical Centre cardiothoracic surgery units.

136 Dr Hardikar told the Court that he had already put forward a proposal to SA Health that resources be pooled with Flinders Medical Centre to collaborate and have a joint waiting list and theatre accessibility.[207] Failing this, he would be open to the option of being able to approach Flinders Medical Centre for theatre space, in addition to the private hospitals.

137 Whether improvements are achieved by sharing resources, swapping patients, or even a complete merger of the waiting list, it is clear that better coordination between these two facilities, providing the same service less than 30 minutes away from each other, is likely to lead to improved patient outcomes.

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200 T591
201 T504-T505
202 T504
203 T592
204 T590
205 T568
206 T407
207 T411

Surgical cancellation processes

138 Dr Hardikar told the Court that he would welcome a policy that required any patient whose surgery is cancelled on more than one occasion to be medically reviewed, if accompanying resources are assigned for this purpose.[208] I pause to note that there was an SA Health policy in place from 6 December 2022 requiring clinical review of patients who have or will exceed the nationally acceptable waiting time for their clinical categorisation. However, it is clear that this policy has not been implemented within the CTSU due to a lack of resources to achieve it.[209]

139 Dr Hardikar said he would also support a mandated policy or procedure that each patient who is postponed receives a call within the following days to see how they are going and determine whether their rescheduled surgery needs to be considered more urgent.[210]

140 Dr Hardikar also addressed a proposal for surgeons to be required to call patients to advise of any cancellations personally.[211] This would allow the surgeon to make an assessment, albeit over the phone, as to whether the patient might need to be reassessed or rescheduled urgently. Dr Viana and Professor Smith expressed concern that this might not be practical within a surgeon's workload.[212] I am uncertain of whether this initiative should be implemented or not. Additional pressure on surgeons who, it can readily be accepted, cancel category 1 surgeries only where it is unavoidable, might not be beneficial in the overall sense. It has the capacity to lead to pressure to perform too many surgeries in a day at the expense of patient safety. However, it might be thought appropriate that a different surgeon, other than the surgeon who has cancelled the procedure, call the patient so that a medical perspective is brought to the patient's case in light of the cancellation. These are matters that the external review should carefully consider.

Future capacity

141 The Court heard that there is an anticipated influx of patients into the CTSU as a result of the introduction of a lung cancer screening program which will increase detection of treatable conditions.[213] Ms Thompson told the Court that the CTSU are expecting an extra 150 lung cancer surgeries per year.[214] Dr Viana estimated an additional 175-190 new cases per year, which he envisaged would certainly create difficulties in managing the waiting list.[215]

142 In light of this impending substantial increase in workload, more efficient and effective procedures are called for. This is a specialist area where the risks are high when things go wrong. I do not suggest that it is for me to solve the issues, however I propose to do what is within my power; make recommendations which will hopefully spur work by those with expertise to identify and implement the improvements needed.

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[208] T404
[209] T543 and Exhibit C9
[210] T404
[211] T412
[212] T483 and T638
[213] T235 (Thompson) and T648 (Smith)
[214] T235-T236
[215] T492

Recommendations

143 The *Coroners Act 2003* requires me to consider whether to make any recommendations which might prevent, or reduce the likelihood of, a recurrence of an event similar to the events which were the subject of the inquest, or which concerns the quality of care and treatment provided to Mr Josipovic, or which might improve public health and safety. A number of issues arose where I consider improvement should be recommended.

144 While the inquest explored the manner in which the Central Adelaide Local Health Network structures its surgical affairs, there is no reason why improvements should not be considered throughout South Australia. I would not wish for another inquest to be required to consider similar issues in another Local Health Network. Similarly, I see no reason why improvements should only be made to cardiothoracic surgery procedures at the Royal Adelaide Hospital. Although I shall confine my recommendations to cardiothoracic surgery, the possibility of deterioration while awaiting a scheduled procedure exists for all surgery specialties and I would encourage SA Health to consider improving the scheduling procedures for all surgical services.

145 I therefore make the following recommendations to the Minister for Health and Wellbeing:

One That clear guidelines for nursing and administrative staff be established in each Local Health Network regarding the information and advice to be given to patients awaiting cardiothoracic surgery who report clinical deterioration.

Two That a formal external independent review of the practices and procedures of cardiothoracic surgical listings be commissioned to analyse the entirety of the patient journey to identify risks that can be addressed. The review should include, but not necessarily be limited to:

a. The referral process, including whether processes in place at Monash Health for cardiothoracic surgery services should be adopted.

b. The capacity of outpatient clinics to provide services in a timely manner, including whether there is a genuine capacity to deal with urgent cases in addition to progressing through routine cases at an acceptable rate (before those cases also become urgent).

c. The costs and benefits of additional theatre lists for services under high demand.

d. The utility of a financial disincentive for overdue category 1 surgeries.

e. The possibility of patient swaps between hospitals when demand for one service is high and there is availability in another.

f. Whether shorter-term listings of specific dates would result in less cancellations.

g. The monitoring of patients awaiting surgery and whether there should be a protocol requiring patient concerns to be raised directly with the surgeon.

h. The manner in which surgical cancellations are dealt with and whether clinician involvement might improve patient safety.

Condolences

146 Mr Josipovic was plainly loved by his family, several of whom attended the inquest remotely. Mr Josipovic's son, Nikica Josipovic, attended the inquest each day in person, and gave evidence on the first day. I could see that there was a tremendous weight felt as a result of identifying that Mr Josipovic was worsening but being unable to have that addressed. I recognise that this is a particularly traumatic aspect of his death. I express my sincere condolences to Mr Josipovic's family.

Keywords: *Cardiothoracic Surgery; Surgical Cancellations; Waiting Lists*